sanatorium admission.[3 4 8] Provided that the care of the patient remains in the hands of the local chest clinic physician, there is a continuity of treatment and follow-up impossible under other schemes. Treatment is undertaken locally, thus making frequent visiting by relatives practicable. The isolation, and possible stigma, engendered by admission to a sanatorium are largely avoided and some contact with the outside world is maintained, thus enabling return to work without the need for strenuous mental readjustment. By all means let us treat this disease "as a military problem," but the essence of a successful campaign is speed and surprise—and who can imagine "sanatoria throughout the country" being built quickly enough to make a rapid impression upon the present tuberculosis problem? Even if it were advisable, where is the money to build such sanatoria? Readjustment of the existing bed complement by the provision of tuberculosis wards in general hospitals is the obvious answer. The major battle in the war against tuberculosis must be fought by the chest clinics; treating patients in associated hospital beds, as out-patients, or in their own homes where necessary, these units can provide a service comparable with the best sanatoria. Furthermore, such "clinic management" of tuberculous patients has such great and obvious advantages socially, clinically, psychologically, and administratively that it should form the basis of the future tuberculosis services.—I am, etc.,

London, W.12. PETER STRADLING.

REFERENCES

1 *British Medical Journal*, 1950, **2**, 61.
2 Heaf, F. R. G. (1950). Ibid., **2**, 1353.
3 Stradling, P. (1951). *Lancet*, **2**, 630.
4 Edlin, J. S., *et al.* (1951). *Dis. Chest*, **20**, 551.
5 *The Protection of the Nurse Against Tuberculosis*, 1952. N.A.P.T., London.
6 Stradling, P. (1953). *Lancet*, **2**, 1185.
7 Ball, K. P., *et al.* (1950). Ibid., **2**, 121.
8 Stradling, P. (1954). Address to British Tuberculosis Association. To be published.

Death from Orange Pith

SIR,—I have read with interest of the death of a man aged 54 from acute intestinal obstruction, due to undigested orange pith, at Lewisham on November 5 (*Journal*, November 27, p. 1301). I had a similar case, but fortunately with a happier ending, and I think it is worthy of record.

On September 29 I was asked to see a man aged 69 who had been suffering from "colicky" abdominal pains and vomiting for 24 hours. The onset was gradual, and the pains and vomiting were increasing in their severity. On examination, he was distended and there was tenderness and guarding in both iliac fossae—the right more than the left. Bowel sounds were very active. I admitted him to one of my beds at the National Temperance Hospital, and, after a short period of observation, decided to operate, the pain and vomiting persisting all the time. Under anaesthesia a ladder pattern of visible peristalsis was noted. A right lower paramedian incision was made, and much free fluid was present in the peritoneal cavity. Distended loops of bowel were seen, mainly involving the small intestine, but the caecum and ascending colon were also affected. The small bowel loops were very congested, with haemorrhagic spots here and there. At the lower end of the ileum, about a foot from the caecum, an oval-shaped lump was noted, and this was lying free within the bowel, and could be moved upwards and downwards. Its nature was in doubt. It was soft and easily indented. The loop of the ileum containing the mass was packed off, isolated, and then incised. A large segment of orange was removed, and this was followed by a rush of foul-smelling fluid, which was evidently the cause of the trouble. After emptying the small gut as far as possible the transverse incision was sewn up vertically, so as not to occlude the lumen. The wound was closed after dusting with sulphanilamide powder, and a drainage tube was inserted through the lower end of the wound. He made an uninterrupted recovery.

The portion of orange consisted of three segments, and, on questioning him, he remembers very distinctly swallowing this piece of orange at his evening meal without chewing it. His daughter, at the time, remarked that he was not chewing his food. It is interesting to note that acute intestinal obstruction, which may be followed by death, may be the result of ingestion of foodstuffs which are not properly masticated. It is well known that tomato skins have previously caused obstruction; it appears that orange pith can do the same.—I am, etc.,

London, W.1. D. H. SANDELL.

Methyl Chloride Poisoning at Sea

SIR,—I read with interest the letter from Dr. J. Crawford (*Journal*, October 9, p. 870). In 1942, while serving in the Royal Navy, I had two cases of methyl chloride poisoning, when I had to rescue the chief engineer and chief stoker of our ship from a cold-room where there had been an escape of methyl chloride gas.

What interested me at the time was the knock-out effect of the gas. The two individuals had been working to locate a leak, and there was no apparent noticeable amount of gas in the cold-room. While they were working they had both gone on their knees and suddenly had received a full breath of the strong gas from the actual leaking pipe. The result was that they were knocked out "cold," and when I went into the cold-room with a respirator two minutes afterwards were still completely unconscious. After being taken to my sick bay, and, using a "novox" apparatus in both cases with artificial respiration, they both recovered in much the same manner as a recovery from an inhalation anaesthetic. Both individuals had amnesia for the events immediately prior to the incident and both complained for two to three days of headache, but there were no after-effects noticeable, and in neither case was there any vomiting. Recovery in the early stage was rather suggestive of someone who had become very drunk and was slowly recovering from a drunken stupor, but this lasted only for about half an hour.

I did not report this incident at the time, as I had no idea whether I was entitled to in view of the wartime difficulties, but, in my time in the Navy, I questioned a number of medical officers, and, as far as I am aware, I was the only one who had had such a case among those I met. Unfortunately I have no notes now of the cases, but these were fully recorded at the time and are in the files of the Admiralty in the journal of H.M.S. *Exe*.—I am, etc.,

Umbogintwini, Natal. TORMOD MACLEOD.

Changes in the Mental Health Services

SIR,—Though there may be many undesirable features in the present observation unit, I think its abolition, as recommended by Dr. J. B. S. Lewis (*Journal*, December 4, p. 1354), would be a retrograde step. Observation units are not a feature of the Scottish mental service, and my experience in England and Scotland convinces me that their absence is a loss. If a patient while in a general hospital becomes mentally ill with a toxic delirium or other mental disturbance, so that he cannot be cared for in a general ward, and is unable or unwilling to sign voluntary papers, there is no alternative in Scotland but to certify him. This is an extremely undesirable step contrary to all modern trends. Were an observation unit available, he could be taken there, and as often as not subsequently returned to the general ward, or discharged to out-patient psychiatric care.

But not only do well-run observation units help the patient, but their development would also benefit the mental health service. Every general hospital group should have a psychiatric service with out-patient clinics, in-patient beds for suitable cases, and an observation unit for disturbed patients. This should not be staffed as a sideline by non-psychiatric personnel, but by psychiatric staff who serve the mental and general hospitals of the area alike. Such an arrangement would encourage a closer co-operation between psychiatry and general medicine so sadly lacking at present. The majority of the nursing staff should be on rotation from the mental hospital, but probationer nurses on the general side could with advantage spend a short period in the psychiatric ward and the observation unit. The barriers between the general and the mental nurse would thereby be lessened, and encouragement given to recruitment for mental nursing,